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Navy Medicine considers for publication photo essays, artwork, and manuscripts on research, history, unusual experiences, opinion, editorials, forum, professional, and clinical matters. Contributions are suitable for consideration by *Navy Medicine* if they represent original material, have cleared internal security review and received chain of command approval. An author need not be a member of the Navy to submit articles for consideration. For guidelines on submission please contact: Janice Marie Hores, Managing Editor, Bureau of Medicine and Surgery (M09B7C), 2300 E Street, NW, Washington, DC 20372-5300. Email: Janice.Hores@med.navy.mil.

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HM3 Kenneth Russell takes a child's blood pressure at a school in Bargoni, Kenya. The Medical Civil Assistance Project (MEDCAP) was part of the bilateral exercise Edged Mallet '07. Story on page 24. Photo by MC2(AW) Jeremy L. Grisham, USN

We Want Your Opinion

Letters to the Editor are welcome. Please let us know what you think about *Navy Medicine*. Please send letters to: Janice Marie Hores, Managing Editor, Bureau of Medicine and Surgery (M09B7C), 2300 E Street, NW, Washington, DC 20372-5300 or Janice.Hores@med.navy.mil.

Online issue of *Navy Medicine* can be found at the GPO website http://permanent.access.gpo.gov/

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A ribbon cutting ceremony took place on base when three renovated houses were donated to Hope for the Warriors by Atlantic Marine Corps Communities on 15 March. MGEN Kenneth J. Glueck, Commanding General of 2nd Marine Aircraft Wing, Robin Kelleher, president of Hope for the Warriors, Shannon Maxwell, vice-president of Hope for the Warriors, COL Adele E. Hodges, Commanding Officer Marine Corps Base Camp Lejeune, Marc Sierra, vice president of Actus Lend Lease, supported the event by attending and cutting the ribbon. Photo by LCPL Brian Jones, USMC, Marine Corps Base Camp Lejeune

Navy veteran Paul E. Baker, center, receives applause after receiving a Bronze Star with Combat "V" from Secretary of the Navy Donald C. Winter, left. Baker was awarded for his actions 62 years ago on the island of Iwo Jima, while serving as a PhM1c providing care to wounded Marines in battle. Rochester, NY, 23 March 2007. Photo by MC Shawn P. Eklund, USN

Integration–The Decision is Yours

RDML Adam Robinson, Jr., MC, USN, Commander, National Naval Medical Center

These are critical times for military medicine. The question before us: should we BRAC [Base Realignment and Closure] or not? Should we continue the integration of Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC)?

If I could take an honest poll of everyone now, I believe it would be surprising to see how many of you have an opinion different from the members of Congress that placed this proposal into law or even different from the leadership of WRAMC and NNMC.

The final product of this historic merger has the potential to be the finest medical center in the world. With this collaboration, we will turn our weaknesses into strengths and our strengths into an indefatigable force. Our doubts will become certainties and our medical advances will be scalable and exportable. This alliance could produce a powerhouse academic medical center and research facility. We are perched to set a whole new standard for military medicine. We have all the ingredients to be successful except the most vital one.

Will we commit to this proposition? To date, many of those involved have not. And this is an all or none proposition. In the 3 years I've been involved in this process, I've heard many reasons for skepticism: no commitment to Graduate Medical Education (GME); no commitment to research; no commitment to the values that we hold dear but are not honored by all.

The integration of these two renowned facilities is an opportunity of the highest order. But, while Force Health Protection is our mission, it will take more than mission to determine the success of this merger. All the latest technology, the architecture and funding will not begin to scratch the surface of what is truly needed to make this integration successful. What I am trying to say is that the outcome of this project, its potential for success is dependent on the people. It is up to all of us, working together, with a positive and constructive mind set that will determine our future. We must stop with parochial attitudes that place our clinical activities and research projects above our patients and our services. We must stop soliciting for more monies and clinical grants and start focusing on our patients and their families. We must stop placing our goals, objectives, and personal advancement above the basic tenets of our services and the Military Health System (MHS).

We can do anything as an open-minded and cohesive team. We can be an academic and research Mecca for the MHS. We must stop our greed and self-aggrandizement and start looking to a philosophy of patient centered care. We must acknowledge that our personal, professional, and spiritual growth as a staff is directly related to our ability to care for our patients and their families.

The quality of patient care has never been an issue. There is no doubt in my mind that we cherish our patients and are committed to their welfare. As leaders in GME and research, we will continue to provide superior education and research opportunities. Most importantly, we will continue to care for our patients. Caring is what makes us great and it is not based upon money or buildings. It is based in our attitudes, hearts, and souls.

Finally, I hope that we have the moral courage to do the right thing—to fundamentally change our selfish interests and embrace real change. Change that can make the National Military Medical Center the best patient centered institution in the world. The decision is yours.

Independent Medical Review Group Presents Preliminary Conclusions

The problems wounded service members and their families experienced at Walter Reed Army Medical Center here are systemic, members of the Independent Review Group said here yesterday. The group met with members of the Defense Health Board and presented preliminary conclusions at a meeting at the hospital.

"There has always been an American ethic and that ethic is that America always takes care of its wounded," said John O. Marsh, co-chairman of the group and former Army secretary. "We've got be certain that we always emphasize that ethic."

The group is looking exclusively at conditions at Walter Reed and the National Naval Medical Center at Bethesda, MD. Yet the group's finding indicate problems beyond the two flagship military medical centers. "We have reason to think that the observations we make are systemic," Marsh said. "We did encounter indications that some of the problems ... do exist in other medical facilities of our armed forces."

Former Secretary of Veterans Affairs Togo West, co-chairman of the group, said there were failures of leadership at Walter Reed. Army Secretary Francis Harvey, Army LGEN Kevin Kiley, and Walter Reed Commander MGEN George W. Weightman were fired for those failures. West said there was a "virtually incomprehensible inattention to non-medical facilities," and an "almost palpable disdain" for the long-term treatment that outpatients need.

Marsh said the circumstances at Walter Reed created a "perfect storm." The Army did not expect the number of injured from the wars in Iraq and Afghanistan. Army officials did not invest in the Walter Reed facility once it was placed on the base realignment and closure list, and they tried to fill the void by hiring contractors to provide critical outpatient services.

Medical personnel did not understand how to cope or treat service members affected by traumatic brain injuries from improvised explosive devices and post-traumatic stress disorder. Finally, there is a systemic breakdown of the disability review process.

The group will recommend speeding up closure of Walter Reed Army Medical Center, West said. Under the base realignment and closure commission, Walter Reed and Bethesda are to be consolidated in Bethesda and the whole complex named the Walter Reed National Military Medical Center. The group recommends speeding up construction at Bethesda and ensuring that there is no "dying on the vine" for the facilities at Walter Reed until the complex is open. This will require funding improvements at a facility that is due to close, group officials said. The group will recommend more money to research traumatic brain injuries and post-traumatic stress disorder. Medical personnel need to know the best diagnostic tools and treatments for these conditions.

The group will recommend more case workers for outpatient service members, and better training for the case workers. The group will also study what part contracting-out played in the hospital's "perfect storm."

Finally, the group is unanimous regarding the disability review process, West said. "The horrors that are inflicted on our wounded service members and their families in the name of physical disability review, simply must be fixed," he said.

All service members go through three separate board proceedings to determine disability. In the Army it is four proceedings. There are different stands and results from these boards and they appear "wildly incomprehensible" to wounded service members and their families, West said.

The system needs to be combined and consolidated into a reasonable process from the service member's point of view, West said. "To be sure it was the degradation of the physical facilities that caught the eye of the media," West said. "Important as that is, we believe there is far more important things to be dealt with here than applying paint or crawling around basements to deal with electrical problems. This is our bottom line: We are the United States of America," he continued. "These are our sons and daughters and sisters, uncles and aunts, maybe even a grandparent or two. ... Their families are our families. We are their neighbors. Their anguish is ours. We can and must do better."

Visit the Defense Department's Web site "America Supports You" at: http://www.americasupportsyou.mil that spotlights what Americans are doing in support of U.S. military men and women serving at home and abroad.

–Story by Jim Garamone, American Forces Press Service, 12 April 2007.

If you would like to be on the electronic mailing list and receive the magazine in PDF format, please contact Janice Marie Hores, Managing Editor, at jmhores@us.med.navy.mil or Janice.Hores@med.navy.mil.

Free Resources for Deployed Service Members and their Family Members

•Free computers for spouses or parents of deployed soldier in ranks E1 - E5.
http://www.operationhomelink.org/

•Free magazines for deploying service members.
https://store.primediamags.com/soldier2/service_member_pg.html

•Free mail/gifts sent to children of deployed soldiers.
http://www.prweb.com/releases/2004/2/prweb106818.htm

•Free phone cards
https://www.operationuplink.org/

•Sign up to sponsor a Sailor/Marine with care packages
http://anysailor.com/ and http://anymarine.com

•Free cookies
http://www.treatthetroops.org/

•Free care packages
http://bluestarmoms.org/care.html

•Virtual Care boxes for troops
http://66.241.249.83/

•Free books, DVD's, CD's.
http://www.booksforsoldiers.com/forum/index.php

•Free care packages
http://www.militarymoms.net/sot.html

•Free care packages
http://operationmilitarypride.org/smsignup.html

•Sign up to receive care packages
http://www.soldiersangels.org/heroes/submit_a_soldier.php

•Free gifts and care packages
https://www.treatsfortroops.com/registration/index.php

•Free shipping materials for mailing to troops
http://www.defenselink.mil/news/Nov2004/n11232004_2004112312.html

One Hundred Additional Recon Corpsmen Needed

Many corpsmen pride themselves in their position on the ground with the grunts. Now, more corpsmen will have the opportunity to practice their trade in the air, land, and sea with the Marine Corps' elite as Fleet Marine Force Reconnaissance Corpsmen.

"We want highly motivated corpsmen of above-average intelligence who are willing to step up to the plate," said HM1 Rudy J. Lopez, Fleet Marine Force Amphibious Reconnaissance Corpsman, 1st Reconnaissance Battalion, 1st Marine Division. "First and foremost, our applicants are out for the challenge to become part of something special."

The challenge: 79 weeks of training in schools offered by the Marine Corps, Navy, and Army.

The schools consist of the Field Medical Service School, Diving Medical Course, Basic Reconnaissance Course, Combatant Divers Course, Basic Airborne School, Special Operation Combat Medic's Course, and Special Operations Medical Sergeant.

It's definitely a gut check," said HM3 Kyle Gribi, a corpsman approximately halfway through the training. "You really learn exactly who you are when you undergo some of the toughest training the United States armed forces has to offer. The camaraderie experienced in these schools is untouchable."

In addition to these schools, corpsmen are able to attend just about every special warfare school offered by the United States. "Corpsmen are easily one of the most diverse ratings in the armed forces," explained Lopez, citing a corpsman who was the top graduate of the Scout Sniper course. Once complete with all schooling, a corpsman will receive multiple pay incentives according to which schools the corpsman attended.

In order to be eligible, a corpsman should be between the grades of E-1 and E-6, younger than 35, have no non-judicial punishments within the past 12 months, and be able to fulfill the 3-year obligation.

For more information on becoming a Fleet Marine Force Reconnaissance Corpsman, contact HM1 Heath E. Harbison at (760) 725-8912.

–Story by CPL Patrick J. Floto, Marine Corps Base Camp Pendleton, CA.

Dental department staff of USS *Dwight D. Eisenhower* (CVN-69), Front row L to R: HM2 Almaz, HM2 Taylor, HM3 Brown, LT Cox, HMC Gill, CDR Sellock. Back row L to R: LT Collins, HM3 Austin, HM3 Ford, HM2 Rojas, ESWS/ EAWS Recipients HN Thompson and HM2 Avila, LT Hoyos, HM2 Smart. Kneeling: HM3 Jamison and QM3 Mendez (Striker). Photo courtesy of LCDR O. J. Stein Jr., DC

Naval Hospital Beaufort Hosts WMD Drill

In December 2006, Naval Hospital Beaufort (NHB) held an unannounced mass casualty/decon drill. The exercise combined the resources of the South Carolina Army National Guard's 43rd Civil Support Team—Weapons of Mass Destruction (CST-WMD) and Beaufort Memorial Hospital (BMH), the local community hospital. The exercise was designed by 1st LT Daniel Fermaglich, Science Officer for the 43rd CST to test specific CST medical capabilities and backup personnel within the operations section of the CST. Additionally, we planned to challenge BMH's Incident Command System (ICS) and Decon Team in conjunction with personnel participating from NHB. Lastly, NHB wanted to expose their new Decon Team members to decon/mass casualty operations to provide an opportunity for NHB and BMH to further develop cooperation for any future potential incidents.

The day-long scenario for the drill started with a disgruntled civilian public works employee upset about losing benefits and employment due to cutbacks on base. This particular individual had a background in chemistry and by accessing public information on the internet, was able to obtain chemical weapons manufacturing information. The suspect acquired the materials necessary to produce small quantities of the nerve agent Sarin. At approximately 5:00 AM the suspect released the agent in the emergency room waiting room exposing several patients and one nurse.

Since the attack occurred at NHB and the decon team was not operational, BMH was notified of the incident and asked to assist. BMH, which was 5 minutes away, then set up its own hospital incident command structure (ICS) which included activation of their Decontamination Team.

Security was dispatched shortly thereafter to locate the suspect at his workplace and secure the unknown chemicals and any reference materials identified. Once onsite, one of the investigating officers succumbed to vapors in the workplace, rendering him unconscious. All victims presented with symptomatology associated with organophosphate poisoning.

In the exercise, eight victims were transferred from NHB to BMH via ambulance and then taken through the decontamination tent, where they were stripped of their clothing, washed down, and scrubbed prior to triage through the ER. The ER staff screened and treated patients for organophosphate poisoning and later released when their symptoms began to subside. "This was a good test of the response capabilities of the incident command structure," stated David Hall, Director of Compliance and Safety for BMH. "We had kept this drill very quiet and wanted to see how well the Team would do at 7:30 AM which would be our shift change."

Once the initial steps were taken to care for casualties, identifying the toxic material occurred next. This required the unique capabilities of the 43rd CST-WMD. This full time National Guard unit has been designed to respond to HAZMAT incidents involving unknown chemical, biological, and/or radiological substances. They assist the incident commander in assessing the situation, providing advice as to appropriate actions required to mitigate the insult, and identifying whatever unknown materials may be present. The team, on call 24/7, is located in Columbia, SC, and was deployed and enroute to Beaufort within 2 hours of notification.

The second portion of the drill (CST response) occurred later at NHB. The 43rd arrived with five specially outfitted civilian-type vehicles designed to provide communication assets to any local responders and to support the Team's mission while onsite. The 43rd integrated into the NHB ICS and coordinated with the incident commander and base security to provide whatever assistance was required. A two-man "survey" entry team was equipped with personnel protective equipment including level "A" chemical suits and self-contained breathing apparatus. Chemical and radiological detection equipment was utilized as they entered the "Hot Zone." The team detected the presence of harmful toxic chemicals and advised the 43rd operations section. This was accomplished through chemical sample testing and photographing materials in the workplace. Once sufficient intelligence and samples were collected, the team left the workplace and went through a thorough decontamination provided by the 43rd CSTs two-man decon section. Afterward, personnel studied all the gathered information, made determinations, and then briefed to the NHB IC regarding mitigation strategies.

Overall, the drill was a major success. It challenged all three of the Incident Command Structures and displayed the collaborative efforts of BMH, NHB, and the Army National Guard who all came together in a time of crisis.

–Story by CDR Eric S. Johnson, MSC, Environmental Officer, Naval Hospital Beaufort, SC.

Naval Hospital Bremerton staff members gather for a group photo upon their return from Expeditionary Medical Facility Kuwait. Photo by HM1 David Menendez, USN

Pistol Qualification Added to C4 Curriculum

LT Sarah Escott, MC, NNMC, Bethesda MD, receives a critique of her performance on the firing range from SGT Robert DiBiase, USAF. Photo by LT Brian Haack, USN

Navy Medical Department officers who graduate from the Combat Casualty Care Course (C4) now have the opportunity to leave with a formal qualification for the 9mm service pistol. The staff at the Defense Medical Readiness Training Institute (DMRTI) have been granted permission after 2 years of wrangling to add a pistol qualification range for Navy officers who graduate from the C4 in response to stated needs from some of the Navy's top Medical Department leaders.

The pistol qualification course represents a new concept in modular training at DMRTI, Commanded by COL Courtney Scott, USAF, Scott says that military training commands have a special responsibility to be resp+onsive to the rapidly evolving needs of the services as missions evolve in the post 9-11 era. Scott understood that hospital commanders are charged with the responsibility to send trained officers to augment fighting forces in theater, but the pressure to fill TRICARE appointment slots often makes it difficult to excuse Medical Department officers for the training they need.

One of the first Navy graduates of C4 since the pistol range was added is LT Sarah Escott. With only 6 months of active duty under her belt, LT Escott, stationed at the National Naval Medical Center, said that the experience was "exciting and empowering." She added that before her training at C4, she had never even touched a weapon, but now feels more confident that if she had to use a weapon in the performance of her duties, she could.

One of the challenges of incorporating weapons training into C4, was to do so without lengthening the course. COL Scott and his staff hope that DMRTI's responsiveness to the Navy's needs encourages more communication and results in DMRTI becoming a first thought in the minds of Navy medicine commanding officers when they have specialized training needs.

–Story by LT Brian Haack, Defense Medical Readiness Training Institute Public Affairs.

Medical/Dental Department aboard USS *Tortuga* (LSD- 46) Back row L to R: HM2 Harris, HN Settle, HM1 Whisler, HM3 Smith, HMC Garza, HM2 Ogans, and LT Gernhofer Front row L to R: LT Kathiria, HM3 Samortin, HMC McMillian, HN Cheung. Photo courtesy of LCDR O. J. Stein Jr., DC

Independent Medical Review Group Holds First Meeting

The Independent Review Group (IRG) established by Secretary of Defense Robert Gates to conduct an assessment of outpatient treatment at Walter Reed Army Medical Center (WRAMC) and the National Naval Medical Center (NNMC) held their first meeting at the Pentagon on 1 March.

The group was established as a subcommittee of the Defense Health Board to review, report upon, and provide recommendations regarding any critical shortcomings and opportunities to improve rehabilitative care, administrative processes, and the quality of life of patients. The review group is composed of the following individuals:

-Togo West, former Secretary of Veterans Affairs and Secretary of the Army under President Bill Clinton

-Jack Marsh, former Secretary of the Army under President Ronald Reagan

-Dr. Joe Schwartz, former Republican congressman from Michigan

-Jim Bacchus, former Democratic congressman from Florida

-Arnold Fisher, senior partner Fisher Brothers New York and chairman of the Board for the Intrepid Museum Foundation

-GEN John Jumper, USAF (Ret.) former Chief of Staff of the Air Force

-LTGEN Chip Roadman, MC, USAF (Ret.) former Air Force Surgeon General

-RADM Kathy Martin, NC, USN (Ret.) former Deputy Surgeon General of the Navy

-SGTMAJ Larry Holland, USA, formerly with the Assistant Secretary of Defense for Reserve Affairs

The group will have special advisors in the areas of social work, rehabilitation, psychological counseling, and family support issues. They will be given free and unrestricted access to facilities and personnel.

"Our overarching goal is to identify any critical shortcomings and opportunities to improve the rehabilitative care, administrative processes, and quality of life for injured and sick members of the armed forces at WRAMC and NNMC, and make recommendations for corrective actions," said Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs.

The group will report their findings and recommendations within 45 days to the secretaries of the Army and Navy and the Assistant Secretary of Defense for Health Affairs.

The charter for this review group can be viewed at: http://www.defenselink.mil/news/Mar2007/IRG_TOR.pdf

–U.S. Department of Defense, Office of the Assistant Secretary of Defense Public Affairs, News Release.

Navy Lab in Indonesia Serves on Front Line of Medical Research

American and Indonesian personnel at U.S. Naval Medical Research Unit No. 2 aim to help protect U.S. service members deployed in tropical regions.

Seventeen Americans and 143 Indonesians serve on the research unit's staff. According to unit officials, the unit's mission is to conduct research and tests in tropical medical and infectious diseases to maintain and enhance the health, safety, and readiness of Navy and Marine Corps personnel in the performance of peacetime and contingency missions in Southeast Asia and other tropical and subtropical regions.

Lynne Pace, wife of GEN Peter Pace, USMC, chairman of the Joint Chiefs of Staff, toured the unit 13 February and met with most of the researchers. Pace praised the dedication of the entire team and said the American researchers have volunteered for multiple tours. "They are here for 2 years, but almost all extend [their tours]," said Pace. "They know they are doing something important to benefit everybody."

The unit's scientists, doctors, and technicians work with their Indonesian counterparts on researching malaria, dengue fever, the Hepatitis E virus, emerging infectious diseases, and other health threats. A big part of their work lately has been research into avian influenza, or "bird flu." Indonesia's National Institute of Health Research and Development hosts the American facility, unit officials said.

The unit spends about 5 million a year on salaries and goods from Indonesia, according to officials. Pace said that some of the equipment is purchased while other pieces of equipment are donated by U.S. and Indonesian charities and companies. "The facilities are not what we are used to in the States," Pace said. "They do not have a big budget, but they make the most out of what they get."

The unit is very much on the frontlines of fighting disease. According to the U.S. Centers for Disease Control, Indonesia has the largest number of avian flu patients. Joint avian flu monitoring by the unit and their Indonesian counterparts will help to pinpoint any outbreaks of the disease or help stop H5N1 bird flu from crossing to humans, officials said.

The research unit has found that the problem in Indonesia isn't the commercial farms, Pace said, but the small farmers with chickens in the backyard. These families live with the birds and are most susceptible to contracting the disease.

The unit also has helped track hereditary factors in contracting SARS virus, and it continues to search for a malaria vaccine and studies drug-resistant parasites that cause malaria. In addition the research unit serves as a collecting point and a clearinghouse for information, officials said.

–Story by Jim Garamone, American Forces Press Service, Jakarta, Indonesia.

USNH Okinawa on Cutting Edge with Surgical Scheduling

Operating room scheduling and administration at U.S. Naval Hospital (USNH) Okinawa will see a major boost in efficiency, thanks to a new software program that went online 1 March 2007. The hospital is implementing the Surgery Scheduling System (S3), a web-based program originally developed for the Army. Offering a variety of benefits, S3 helps operating room staff streamline the surgical scheduling process, increases reporting accuracy and improves overall management efficiency.

The program already has been deployed to Army facilities worldwide and is in use at a handful of naval hospitals. NH Okinawa is on track with the program and has already begun to enjoy the benefits of S3. "The program is installed, and training is underway with a fully operational," said CDR Terry V. Bola, department head of operative care at USNH Okinawa.

According to Pamela Porch, S3 project director for the U.S. Army Medical Information Technology Center (USAMITC), the S3 program is cost-effective and easy to use. "The system is web-based and easily accessible on the hospital intranet. The intranet based feature also allows access to the program from any location in the hospital, including inside the actual operating rooms," said Porch.

Data entry and appointment scheduling can now be done in real time by the surgeons themselves, according to CAPT Susan Chittum, director of Surgical Services. Chittum explained the surgeon and the patient can sit down in the doctor's office during a pre-operative appointment and schedule follow-on appointments together, rather than coordinate with another staff member assigned to maintain the operating room schedule. The S3 system also ensures a greater degree of patient privacy. "Access to the program will be limited to user accounts with different levels of permission, depending upon what the user's job assignment is," said Chittum.

The program can generate operating room schedule reports for the chain of command that omit sensitive patient information, keeping privacy-protected information on a strictly need-to-know basis, she added.

The S3 program was initially developed by an engineer at Tripler Army Medical Center in Hawaii to improve the overall efficiency of the operating room. The program was such a success that the Army Medical Department implemented it as the preferred tool for improving the management process of surgical scheduling.

Since the deployment of S3 at Naval Hospital Okinawa, the Navy's Bureau of Medicine and Surgery (BUMED) announced that the BUMED Information Technology (IT) Management Control Board selected S3 as the program of choice for the operating room management of surgical case scheduling for all Navy hospitals. "The goal from the IT Management Control Board is to align the Navy with the Army and by getting rid of redundancy within both of the military medical arenas, have all the Navy using the same computer systems that are web-based and centrally managed," said CDR Cynthia Turner, perioperative nursing program instructor at Naval Hospital Camp Pendleton.

Officials at NH Okinawa consider S3 another step forward in their continuous efforts to leveraging technology to improve patient care and operating efficiency.

–Story by Brian J. Davis, U.S. Naval Hospital Okinawa Public Affairs.

NH Bremerton Recognized for Excellence in Mother-Baby Care

Naval Hospital Bremerton's commanding officer presented her staff with the DOD Military Health System 2007 Obstetrics Satisfaction Award at a ceremony held on the hospital quarterdeck 9 February.

CAPT Catherine Wilson, the hospital CO, received the award herself on behalf of the hospital at the MHS 2007 Annual Conference in Washington, DC, on 31 January, but said it was her hospital team back in Bremerton, WA, who deserved it the most. "It made me proud to receive that award, knowing I would come back to the real ceremony and be able to give it to those that really matter," she said to the assembled staff at the hospital's ceremony. The award singles out NHB's labor and delivery ward from all military treatment facilities in the continental U.S. But although the award is written in the name of the hospital's obstetrics program, it really recognizes departments across the entire hospital that contribute to the success of any single ward. "This award comes to the NH Bremerton team, not one single person or department," said CDR Charles Lamb, the hospital's director for specialty services.

CDR Charles Lamb, director for specialty services, receives the Department of Defense 2007 Obstetrics Satisfaction Award from CAPT Catherine Wilson. Photo by MC1(SW) Fletcher Gibson, USN

During the ceremony, special mention was given to all of the departments involved in the efforts that lead to the Obstetrics Satisfaction award. From the nursing staff to food services to the dentist who uses his casting equipment to make molds of tiny hands and feet, the otherwise specific award succeeded in acknowledging the team effort that goes into NHB's work environment.

All told, 27 staff members from 11 departments were called up during the ceremony to help receive the award. The award was granted in the field of customer satisfaction and directly reflects the comfort the hospital's patients feel during obstetric care.

–Story by MC1(SW) Fletcher Gibson, Naval Hospital Bremerton Public Affairs.

Naval Hospital Okinawa Bests All DOD Overseas Hospitals

U.S. Naval Hospital Okinawa stood out among all overseas Department of Defense hospitals in 2006, earning special recognition at the 2007 Military Health System Conference for the hospital's care of pregnant mothers and their babies.

CAPT Peter F. O'Connor, commanding officer, presented his staff with the TRICARE Obstetric Care Patient Satisfaction Award 22 February at the Camp Lester Chapel. The hospital received the award for having the highest inpatient satisfaction rating for the care of women and

their babies during pregnancy and about 6 weeks after childbirth. According to the award citation, the hospital provided excellent care by listening to patients and treating their concerns. The staff was also responsive to the physical and emotional requirements of all its patients.

LCDR Angela Stanley accepts the TRICARE Obstetric Care Patient Satisfaction Award from CAPT Peter F. O'Connor. Photo by HM3 Tina M. Felipe, USN

"It's really good to see some recognition for the hard work our staff puts in all year," O'Connor said. "The staff worked hard to care for all the service members and families in Japan and the operating theater. With more than 100 deliveries a month, keeping the patients satisfied is a marvelous feat."

O'Connor also recognized CDR Elizabeth Beazley, a family medicine physician, with the TRICARE Health Innovations Program Award.

In 2005, clinics at Camp Foster and Marine Corps Air Station Futenma stopped treating civilian patients. This change caused a decline in patient care and satisfaction. Beazley led a team that increased patients' access to care when it opened the Lester Family Medicine Clinic. "We gained 5,000 family members because of the unique clinical situation," Beazley said. "We analyzed the problem and developed a plan to change the clinic's settings and increase the number of doctors, family medicine physicians, physician assistants, nurse practitioners, and corpsmen in the section."

As a result of the team's hard work, patient satisfaction increased by 400 percent and wait time decreased by 75 percent, according to the award citation.

"I get stopped at the commissary because people say the care at the hospital is so wonderful," O'Connor said. "We worked on this problem for over a year and a half. The patient dissatisfaction we saw then can't be seen today, and that's how it should be."

–Story by LCPL Juan D. Alfonso, USMC, Marine Corps Base, Camp Butler, Okinawa.

NMCP Trains Deploying Corpsmen in Casualty Care

"GO! GO! GO! GO SAVE YOUR BUDDY!" yelled CDR Tom Craig, MC, emergency medicine physician at Naval Medical Center Portsmouth (NMCP).

On 5 April 2007, he and CDR Tim Coakley, also an NMCP emergency medicine physician, led 16 corpsmen and several counterparts representing the Army and Joint Task Force in a simulation of an attack in Iraq. Only they weren't in Iraq; they were on a riverbank in Portsmouth, VA.

Their challenge: safely getting to their "injured" buddies, assessing their condition, and treating them while in battle. It was part of a valuable warm-up for what the corpsmen might soon face when they deploy to Iraq and become the "doc" to the boots on the ground.

This was the final exercise in the week long Casualty Care Course. Termed a "just-in-time skills refresher," the course is coordinated by Craig and Coakley, who are former corpsmen themselves. They and hospital corpsmen HM2 Otis Seamon and HM2 Harold Butac are the instructors. All have served in Iraq.

"It's a prerequisite that our instructors have served in Iraq," said Craig. The instructors share their experiences and give the deployers an unvarnished account of what to expect. The corpsmen learn about IEDs, blast injuries, burns, weapons safety, what medical items will be in their packs and how to medevac a patient. Coakley added, "This is serious as a heart attack."

For 3 days, the 16 corpsmen worked in NMCP's Sim Center—a hands-on lab where they practiced lifesaving care on life-size interactive dummies with simulated injuries. The skills refresher includes airway management to facilitate breathing, chest and extremity trauma, hemorrhage control, clotting agents, pressure bandages, IV access, splints, and tourniquet application. They learned how to perform a "cric" (pronounced crike–short for cricothyrotomy), which is a temporary tracheotomy.

On day 4, the corpsmen donned flak jackets, Kevlar and their medical backpacks in a simulated attack. The victims, made up in moulage, fake blood, and prosthetic injuries, lay "wounded" on the shoreline. It was time for the corpsmen to put their battlefield skills to work.

"TAKE COVER! STAY LOW! STAY LOW!" admonished Craig, as the corpsmen rushed to attend to the wounded.

Corpsmen, like their medical counterparts in the civilian world, are trained to care for patients in a hospital or clinic setting. Then they have the added duty of administering care in war and on the battlefield.

HM3 Shawna Mock has been in the Navy for 5 years and has served in Kuwait. "I've worked in the emergency room and have had clinic experience. But we're going to be out there in the field and we've got to know what to do on the

CDR Tom Craig, emergency medicine physician, explains battlefield skills to corpsmen during a mock attack on the Portsmouth waterfront. Photo by MCAA James M. Holcroft, USN

battlefield – how to carry wounded people back to safety. This (training) has been very beneficial. You don't need 'Gucchi' high-tech gear; you can use duct tape and your brain."

Craig is a big proponent of duct tape. "It's a bandage; you can strap arms to the body; strap legs together… Gear doesn't matter. Improvise!

"They come into class not knowing how long to keep a tourniquet on," Craig added. "We tell them, 'Don't second guess. If you think they need a tourniquet, use a tourniquet. Stop the bleeding.'" If arterial bleeding isn't stanched in 3-4, the person will bleed to death.

"Number one is hemorrhage control. They've got to stop the bleeding. It's the biggest killer on the battlefield," said Coakley. "Number two is emergency airway management. Keep them breathing."

This was the fifth time Craig and Coakley have conducted the Casualty Care Course. They try to do it every 3 months to prepare a new group of corpsmen deploying to Iraq. The participants volunteer for the course, and all were unanimous about its value.

HM3 Mark Foriska said, "It's an outstanding class. The docs and enlisted folks are doing an outstanding job. A lot of stuff we're doing now, you can't get in a textbook."

Craig added, "We keep it real, give them the 'tried and true', and the tips and secrets we found in Iraq. There's no fluff. It's all about the corpsmen so they'll be ahead of the game when they get out there. It's a steep learning curve."

Craig and Coakley are already looking ahead to the next course and a new group of corpsmen students in early summer. The Navy's Bureau of Medicine and Surgery (BUMED) is looking at the course as a prototype that can be conducted at other naval hospitals.

–Story by Deborah R. Kallgren, Public Affairs, Naval Medical Center Portsmouth, VA.

Sailors Bring Goodwill and Medical Care to the Philippines

Two teams of physicians, corpsmen, and dentists with 3rd Marine Expeditionary Brigade and USS *Comstock* (LSD-45) worked alongside medical teams from the armed forces of the Philippines and the Philippine National Police to provide medical services to people located in evacuation and transition centers near Legazpi.

More than 15,000 people have been displaced to campsites after a series of natural disasters forced them from their homes in early December, and have been with little or no medical attention since then, according to CAPT David Lane, MC, the Medical Detachment Commander for Operation Goodwill III. "There was a shortage in medical care in the area before the devastation of the people's towns, and now there are no medical clinics for the people. Their medical needs are not able to be met," said Lane. "The medical teams are here as part of Operation Goodwill III to give help and relief to the residents of the campsites."

For many of the patients it was the first time they had received medical attention. Jesus Guarin, 47, who suffered the loss of his right leg below the knee due to diabetes, was seen for the first time since the amputation by the 3rd MEB corpsmen.

"The number of patients who came through and haven't been able to get the proper medical attention was astounding," said HM3 Courtney Preaster. "Having the opportunity to better the people's lives even in the slightest bit makes me feel better."

Lane said the medical teams were doing much more than seeing the patients who came through for treatment. The medical teams provided vitamins and hand soap, which the people could not afford, cleaned and sanitized latrines, educated the people about proper sanitation, and gave instruction to parents on how to care for their children at home.

HM1 Andray Williams examines a Filipino child's new cast. Photo by LCPL Daniel R. Todd, USMC

"The people were so grateful for everything. Seeing them smile was one of the greatest moments of my life," said HM2 Ernest Fernandez.

Each medical team will travel to three sites over 6 days during Operation Goodwill III and provide primary medical and dental services to the people there.

–Story by LCPL Daniel R. Todd, USMC, Marine Corps Base, Camp Butler, Okinawa.

Marines Rescue Iraqi Family from Accident

Marines from Scout Platoon, Headquarters and Service Company, 4th Tank Battalion, saved the lives of a 5-year-old Iraqi boy and his family when Marines came to the aid of an overturned vehicle outside of Fallujah, Iraq.

The Marines were traveling down one of the main roads when they stopped due to a suspected improvised explosive device. While posting security, two Marines looking through binoculars watched as the driver of a vehicle lost control and flipped his car several times. The car finally came to rest on its roof.

After the IED that caused the halt originally had been determined to be a false alarm, the Marines moved in to help the vehicle's occupants. HM3 Maurell D. Higginbottom, the patrol's corpsman, approached the scene while the other Marines established a security cordon around the accident. "When we (arrived) at the accident we noticed most of the family was sitting on the edge of the road with other Iraqi people attempting to help," explained SSGT Juan Verdura, platoon commander. "I immediately instructed (Higginbottom) to assess the family."

Before "Doc" Higginbottom could begin his assessments, the father of the family pointed at the overturned car and shouted, "Baby!" This set off alarm bells in the heads of the Marines. They ran to the vehicle and checked for a child but did not initially find one, Verdura said.

Unwilling to give up the search for a wounded baby, as many Marines as possible squeezed around the overturned sedan, flipped the vehicle onto one side and held it up. As the Marines lifted the vehicle, the body of a badly-wounded little boy was discovered. Verdura grabbed the boy and yelled for Higginbottom, who rushed to his side.

Using his training and the medical tools at hand, Higginbottom opened the boy's airway. He immediately started breathing. Verdura instructed the father to keep the boy as calm as possible due to his injuries, he said.

As the events unraveled, SGT Christopher P. Olloqui, the convoy commander, immediately called for a helicopter to evacuate the family, all of whom had varying degrees of injuries from the accident. "Our first priority was getting this family to a hospital," Olloqui explained. "I'm very glad we were here to help these people. That's the whole reason why we're here." The medical evacuation helicopter landed and

Marines from Scout Platoon, Headquarters & Service Company, 4th Tank Battalion, Regimental Combat Team 6 provide first aid to an Iraqi family involved in a serious motor vehicle accident. Quick thinking and action saved the lives of all involved. Photo by CPL Alexander E. Escobar, USMC

transported the family to Camp Taqaddum Surgical. Verdura, who flew with the family to give a statement about the event, waited by the surgery room to hear news about the boy's condition. "When the doctor came out and told me everyone was stable I felt a wave of relief pass through me," expressed Verdura. "Looking at the little boy, who (resembled) my little nephew really hit home to me." Verdura said he knows if it wasn't for his team, the little boy wouldn't have made it.

Given the relatively limited medical resources in the region, this case could have turned out tragically if the Marines had not happened to be so close to the scene of the accident. Instead, quick action by the first saved the life of a little boy and prevented any greater harm coming to the rest of his family.

–Story by LCPL Randy Little, USMC.

HMCS Scott Allison, leading chief petty officer of Explosive Ordnance Disposal (EOD) Mobile Unit (MOBU) 2, explains an interactive video of the inner workings of the turret on the USS *Monitor* to his children during a visit to the USS Monitor Center in Newport News, VA. Photo by MCSN John Suits, USN

Medical Officer Provides Care and Compassion for Iraqis

Marines and sailors from 3rd Battalion, 6th Marine Regiment, have a key player in their efforts to earn the trust and respect of the Iraqi people. LT Van A. Willis, the battalion's medical officer, joined the Marines of Weapons Company as they went to houses where they knew there were Iraqis who needed help.

"We went on patrol the day before LT Willis came out," said HM Marquintus D. Edwards. "We came across a couple of houses that had people that needed help and medical attention. We're trying to win the trust and respect of everybody out here, so we called to have LT Willis come out."

Willis eagerly accepted the chance to treat people who needed his help, who says he looks forward to every opportunity to get out amongst the people. "They had asked for a medical officer to come out there and look at some of the people that they thought needed a little more attention than what your basic corpsman can provide," added Willis. "I volunteered to go out there and see the patients."

He saw and treated three patients on this patrol, each with their own unique ailment. The first stop was a baby with pneumonia, which is more of an environmental issue from living in poverty conditions, said Willis. The second was a teenage girl that initially was thought to have been burned on her back, but the irritated area was ultimately diagnosed by Willis as a skin infection. The final stop was a infant who was having problems keeping its food down from not being burped after eating.

Treating patients in Iraq is a long way from the sterile, starched environments Willis imagined himself operating in after graduating from the Kansas City University of Medicine in May 2005. "I pictured myself working in an operating room somewhere in a big university hospital," he said. "The last thing I thought I would be doing was being in bombed-out buildings in Iraq treating the locals."

LT Van A. Willis, MC, treats a newborn child with digestive problems. Photo by LCPL Christopher Zahn, USMC

While not what he imagined, the experience has been an enlightening one for Willis. "This is by far the most rewarding thing I have ever done in my medical career," he added. "In the past 6 years I have worked in hospitals, clinics, surgery rooms, all over the place, but never had I seen truly the impact that medicine can have on another human being like I have out here amongst these people. It may not be the cure for their problems, but just seeing the gratitude and appreciation in their eyes and their smile is truly the most rewarding part of what we do and why we do it. I just wish we could do more for these people, but we do what we can, as good as we can, for as long as we can."

–Story by LCPL Christopher Zahn, Regimental Combat Team 6, Habbaniyah, Iraq.

TQ Surgical Responds, Treats Truck Bomb Casualties in Habbiniyah

Physicians and hospital corpsmen hustled through the hallways at the Camp Al Taqaddum surgical facility 24 February, some with bootlaces still untied after responding, on a moment's notice, to an incident call. They maneuvered through the hundreds of service members from around the camp who were now filling the halls waiting to donate blood or assist hospital staff in any way.

The afternoon had progressed with relative ease until shortly after 4:00. That's when the unit received a call on their radio, informing them of a blast that occurred in northern Habbiniyah. The call's estimate warned them to prepare for mass casualties, the numbers uncertain but surely high.

"It got kind of hectic about 10 minutes after the call when the first ambulance came in," said CPL Robert S. Talbot, a squad leader for the detachment's security platoon, 2nd Maintenance Battalion, 2nd Marine Logistics Group (Forward). "I started helping unload the patients."

The blast did not discriminate, killing and maiming men, women, and children alike. It came from a suicide truck bomb loaded with rocks and ball bearings near an Iraqi police station, a school, and a mosque where Iraqi civilians were exiting after evening prayer. Reports indicate that the blast killed 31 Iraqis and wounded another 75.

"They decided to take a few Marines out to Habbaniyah. They were going through the rubble of the mosque to recover victims," explained Talbot.

A corpsman with Multi-National Security Transition Command-Iraq who participated in the search described the scene. "It was chaos," said HM2 Franklin J. Weaver. "They were running around screaming and crying, covered in blood. The explosion pretty much annihilated the entire block."

Weaver and the other service members transported Iraqis from the site to the surgical facility. Many were then transported to higher levels of care. Most injuries consisted of broken bones and wounds from shrapnel and fragments.

Patient after patient, hour after hour, the doctors and corpsmen treated the wounded with the help of service members from different job fields and services who flocked to the

facility to assist. Twenty-three troops donated their blood to help the victims.

A 46-year-old Iraqi man on a stretcher was bleeding internally, sustaining injuries to his abdominal area and right arm. Marines and sailors carried him through the triage area in the lobby, past an Iraqi man and his wife cradling their crying infant and into Operation Room 3, the doors closing behind him.

On the other end of the building, corpsmen and doctors continued to provide treatment, but experienced an overload of patients requiring transportation to a higher level of care. "Are we going to get these patients out of here soon?" a corpsman asked a doctor. The doctor was unsure.

In OR 3, the 46-year-old man had been anesthetized and prepared for surgery, with a catheter and breathing tube inserted. "You can get started when you're ready," a corpsman called to the surgeon from the sink.

CDR Theodore D. Edson, a general surgeon and the chief of surgical services with CLR-15, 2nd MLG (Fwd), made an incision down the length of the man's stomach. Edson and LCDR James Christopher, another general surgeon in Edson's unit, began to search for any internal bleeding in the man's small intestine.

A sailor with a clipboard poked his head through the door. "What's the patient number?" he asked. "2191," said HN Andrew T. Hunter, an OR technician with the unit. The corpsman wrote it down and walked down the hall, where a senior chief petty officer rushed into the room to pass some crucial news.

"We got a bird," he announced, referring to the CH-46E helicopter that would be transporting patients from Taqaddum.

Marines and sailors in the building responded to the announcement. "One, two, three," a group of Marines said as they lifted a stretcher carrying an 8-year-old Iraqi boy. They made their way out the door and others followed, forming a long line of stretchers headed to the aircraft.

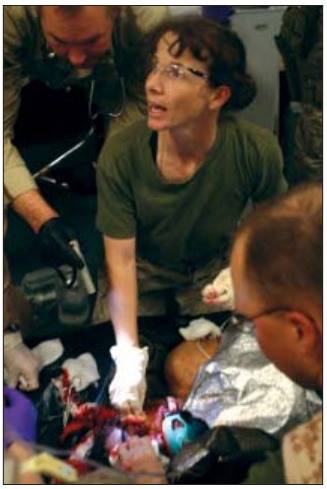
By this time, patient 2191 was more than an hour into surgery. Doctors Edson and Christopher were working to stop the bleeding they found in his small intestine. The doctors also came across a badly damaged segment of intestine which they removed and stitched back together. Hunter wiped the sweat off Christopher's forehead with a towel as the surgeon continued to operate.

The man's heart rate was now stable, near 75 beats per minute. Prior to surgery, it had topped 120. He was one of the many patients who would require transportation to Baghdad or Balad for additional treatment.

Outside OR 3, service members continued to assist the hospital staff, joining the doctors in their hustle through the halls, retrieving gear and information. A Navy lieutenant junior grade and Marine master sergeant sat on the floor and played tic-tac-toe with an 11-year-old Iraqi boy. Another Marine was told to stay with a group of children for the rest of the night.

"I had to keep one of them awake because he had a head injury and if he went to sleep he might not wake back up," said CPL Julia K. Venegas, an intelligence analyst with 2nd MLG (Fwd).

A hospital bed was now being pushed on wheels through the halls toward OR 3. After a little more than 2 hours of surgery, patient 2191's bleeding had been stopped. His abdomen was stitched shut and his body checked once more to ensure no injuries had been overlooked. As the man regained consciousness, he moaned after the doctors removed his breathing tube. "He has a lot of pain," Edson said. The doctors put a cast on his possibly broken wrist. He was hardly conscious.



CDR Pamela C. Harvey, Taqaddum surgical detachment emergency medical officer, treats victim of the truck bomb blast.
Photo by SGT Josh Hauser, USMC

The doctors and corpsmen gathered around the patient's bedside and grabbed onto the sides of his blanket. "One, two, three," they counted before lifting him to the bed. The man moaned as they set him down and moaned again when they adjusted his position. He was taken to the Post Anesthetic Care Unit, where he awaited transfer to a hospital in Baghdad. This man was one of 10 to receive surgery and one of 50 to receive treatment that night at Taqaddum's surgical detachment. Six were fully treated and released the same night. "There's no doubt we made a difference," said Weaver. "A lot of lives were saved."

Due to the efforts of medical personnel, only one of the attack's victims died at Taqaddum surgical facility. This was not the kind of night the staff asked for, but it was certainly one they were trained for and one few are likely to forget.

–Story by LCPL Andrew Kalwitz, 2nd Marine Logistics Group, Al Taqaddum, Iraq.

"Ugly Angels" Prepare to Save Lives

Screams come from inside a CH-53D Sea Stallion. Bodies cover the area around the Aircraft Rescue and Fire Fighting compound. The situation: two Sea Stallions have collided over the Marine Corps Air Facility's runway, and causalities are in dire need of medical assistance.

This scenario was only an exercise, but the Marines and sailors of Marine Heavy Helicopter Squadron 362 reacted at the scene as if it were real.

The purpose of the drill was to provide training to the flight surgeon, corpsmen, combat lifesavers, and field aid station personnel. The training concentrated on the area of mass casualty, triage management, and proper response to an onboard mishap.

"We handled the triage of a mass casualty scenario and the clinic received the casualties," said LT Robert J. Matyas, HMH-362's flight surgeon. "This is in preparation of a real event that could possibly happen in Iraq. It's a training evolution that the squadrons do to prepare for the real thing in theater."

During the exercise corpsmen and combat lifesavers evacuated the injured to a safe area before beginning to treat them.

After receiving an intensive 3-day course on medical treatment, the combat lifesavers were up to the challenge of taking care of injured personnel. During the combat lifesavers course, the Marines learned how to perform cardiopulmonary resuscitation, use of tourniquets, and how to save someone's life due to a collapsed lung.

"As part of our squadron's Block I and II training for [Operation Iraqi Freedom], it was required that we have combat lifesavers," said SGT Jean F. Durham, the unit's operations chief. "I've always found the medical field something I wished I had gotten into, so I immediately volunteered. "Our squadron's corpsmen and flight surgeon provided all the training. The information given was very thorough because it was broken down step-by-step. They made us feel very confident before going out there."

Going through the course, the Marines felt like they have gained valuable training and confidence should this type of event arise in Iraq. "My job was to be the combat lifesaver course instructor for the drill" Said HM2 Ivan R. Mago. "We successfully completed the classes in 3 days. Prior to that I organized the setup of the classes."

HM2 Ivan R. Mago, checks the vital signs of a Marine who was "injured" during an accident. Photo by LCPL Edward C. deBree, USMC

Mago said he feels he and the other corpsmen and combat lifesavers are prepared to go to Iraq and handle a situation like this, as does everyone else.

"They are most definitely ready because I've seen them take the course and I've seen how they react to different situations," said Matyas. "They all demonstrate skills accurately and successfully. They also remain calm in chaotic situations. They're well trained and have good leadership."

With the squadron's deployment drawing closer, the Marines feel they are ready to do their job in Iraq.

–Story by LCPL Edward C. deBree, Marine Corps Base, HI.

Ceremony Brings Together Former Commanding Officers

On 11 April 2007, former commanding officers gathered to assist CAPT Colin Chinn, MC, USN, NHOH commanding officer, in unveiling the Naval Hospital Oak Harbor Commanding Officer History Wall. RADM William J. McDaniel, MC, USN (Ret.) was the most senior leader in attendance followed by CAPT Herbert A. Speir, MSC, USN (Ret.), CAPT Michael W. Benway, NC, USN (Ret.) and CAPT John E. Tracy, MSC, USN (Ret.). Also in attendance were two former Executive Officers CAPT Roger Case, MC, USN (Ret.), and CAPT Richard A. Becker, MSC, USN (Ret.).

–Story by Sharon S. McIntyre, Oak Harbor, Public Affairs.

From L to R: right: RADM W. J. McDaniel, CAPT H. A. Speir, current CO, CAPT C. G. Chinn, CAPT M. W. Benway, and CAPT J. E. Tracy. Photo by Sharon S. McIntyre

True Courage Under Fire

Denene Brox

CDR Lenora C. Langlais, NC

Even before she was awarded the Purple Heart, CDR Lenora Langlais exemplified what it means to be a true nursing leader.

CDR Langlais, an officer in the Navy Nurse Corps, doesn't sugarcoat what it took to reach officer rank in three different branches of the military, obtain two post-graduate degrees with plans to get a doctorate, and be awarded the Purple Heart for her service in Iraq, all while remaining a dedicated wife and mother. "It took hard work, determination, and support from my family to get where I am today," she declares.

Before entering the military, Langlais worked as a civilian nurse after graduating from Villanova University College of Nursing in Villanova, PA. Her career path as a military nurse began in the Air Force Nurse Corps in 1988 and has followed a uniquely winding course over the past 17 years. Langlais served 4 years in the Air Force, 5 years in the Army and has been in the Navy for 8 years.

"I've been blessed to be able to take my skills and use them in the military," she says. "I wanted to travel and use my nursing skills, so I have the best of both worlds. The pay and educational opportunities in the military were [vastly superior to what was available in] the civilian sector. The military trained me and gave me the opportunity to utilize my training in a proper setting."

CDR Langlais believes her family and faith have been paramount in her success, including her recent service in Iraq as a combat nurse. The mother of five children, including six-year-old twins, Langlais explains that her family supports her career without hesitancy. "My husband is a Navy engineer, so he has a clear understanding of what [this life is like]. He is retiring in January 2007 and I will complete my service in 2011."

During her long and varied career in the military, Langlais has worked in many areas of nursing, including the ER, oncology, critical care, and combat trauma units. Today she draws on her experience as both a civilian nurse and a military nurse to help other Navy nurses make the transition back to civilian life. "I'm on a core staff that assists nurses and helps them use the skills and experiences they have from being in the Navy in the 'real world,'" she says.

In the Line of Fire

In February 2006, CDR Langlais went to Iraq, where she found herself serving as the only African-American senior combat nurse in the town of Al Taqaddum, on the outskirts of Al Fallujah. During her 5 ½ months there, she worked in combat trauma care, serving many severely wounded patients.

"I saw a lot of people die. I saw a lot of severe injuries. That's what happens in wars," she says matter-of-factly. "There is a difference between witnessing trauma as a civilian nurse and as a combat nurse. Civilian nurses will see patients come in with gunshot wounds, and it's hard. But in a war you see wounds from explosions, and human bodies so damaged. Our medical technology hasn't advanced far enough to keep up with these types of injuries. I prayed to God for guidance on how to care for these people."

On 7 April CDR Langlais was coming out of the galley when she was hit by the second of four rounds of mortar blasts. "The base I was on was very close to Habbaniyah and it was very busy with insurgents day and night," she says. "Through intelligence, the insurgents learned that the base was highly populated." Fortunately, she survived the blast and no other military personnel were injured.

Although she has now recovered from her injury, she still feels its lingering effects. "I have damage to my face," she explains. "The injury is from my cheekbone down past my chin and neck. I went through exploratory surgery after the attack. I have no feeling at all on the right side of my face due to nerve damage. Whether or not I ever recover feeling depends on if the nerves regenerate."

In a remarkable display of bravery and dedication to her duty as a combat nurse, CDR Langlais refused to leave work after she was injured in the blast. "There were too many junior nurses there who needed me," she recounts. "The night of my injury, we had a patient who was having an allergic reaction to medication and I gave him care to help him breathe. They weren't too happy with me for continuing to work, but I wasn't going to let him die in front of me."

She stayed on in Iraq for 3 months after her injury. "I was treated and recovered in a combat zone. I came home 2 months early and experienced a lot of guilt because of that."

People who know Lenora Langlais say this dedication to putting the needs of others before her own is typical of her. "She is an inspiration simply because she cares," says Chaplain Terrell Byrd, who served with CDR Langlais in Iraq. "She cares about people, her job, her profession, and her family. She is an inspiration because she came to Iraq as a volunteer. She didn't have to at her level, but she chose to be at the front of the fight. As a wife and mother of five, I can only imagine her difficulty in making that decision. Even when she was wounded she decided to stay to set an example [of courage] for her young corpsmen."

A Humble Hero

Despite everything, CDR Langlais feels that "overall, being in Iraq was a wonderful experience." Does she consider herself a hero? "No," she says simply. "I consider myself a naval officer who is a nurse."

But that's not what the Navy thought. Upon returning home to Camp Pendleton, CA, CDR Langlais was awarded the Purple Heart for her courage under fire.

The idea of honoring American soldiers for bravery in the face of war is credited to the nation's first president, George Washington, who wrote: "Not only instances of unusual gallantry but also of extraordinary fidelity and essential service in any way shall meet with due reward."

That description is a perfect fit for CDR Langlais. "While deployed and in her personal time, she rendered the personal touch," Chaplain Byrd says. "In Al Taqaddum, during her tenure, I don't know of anyone who did not know her name. There were those who would stop to say 'thank you' to her for the time she took with an injured soldier, sailor, Marine or airman. During very difficult and long medical procedures, she took time to explain what was happening to the military member. CDR Langlais is a natural leader who embodies all that is best of the naval service and the healing arts."

Through it all, she remains humble. "I am blessed," she says. "God was watching my back that day. My head could have been blown off. But I survived my injury, I can speak, and my face is fine. I served my country, took one for the country,and lived to talk about it. I'm grateful for that."

Despite being wounded, CDR Langlais is still willing to return to Iraq if she were to receive the call. "I would go back," she declares. "I'd pray about it and discuss it with my family, but I am willing to serve my country again."

The Face of Diversity

When the Navy is looking for a nurse who embodies dedication and hard work, they turn to someone like CDR Langlais. She was chosen in 2005 to be featured in the Navy's recruitment advertising campaign to be the face of the Navy Nurse Corps.

"It was a selection process that included quite a few candidates," she explains. "They picked me because they thought I had the most appealing personality and smile and I was truly living what the ad represents."

CDR Langlais is a model in every sense of the word—not only in the Navy ads, but also a role model for others who hope to follow in her footsteps. She travels to universities around the country to recruit other minority applicants into Navy nursing. "I'm hoping that my presence is helping to make a difference, and it does hold people accountable. I lead by example," she says. "Unfortunately, minorities still experience the glass ceiling. We see where we can go, but we can't always get there."

The road to personal and professional success is often paved with adversity, and CDR Langlais has been no exception. As an African-American woman, she has felt the pain of discrimination. But by continuing to reach higher in educational and professional pursuits, as well as serving her country, she has literally become the picture of success.

"Being the only African-American nurse and female officer on the entire base came with a price," she says of her service in Iraq. "It was a challenge for people to be open-minded enough to take leadership guidance from me. I was labeled as confrontational and mean. If you're anything other than [the stereotype of] a video vixen or basketball star, they can't handle you. In their mind you're being confrontational. But other people's small-mindedness is not my problem. I never allow those issues to interfere with my patient care."

CDR Langlais receives her Purple Heart. Photos courtesy of Denene Brox

What advice does CDR Langlais have for other minority nurses who are considering a career as a military nurse? First, she recommends that you "really do your research" on the nursing profession as well as on the particular branch of the military that you're interested in. "Interview recruiters and ask lots and lots of questions," she says. "And then ask more questions and keep asking questions again and again. Check out the recruitment office after hours when they're not expecting you to be there."

Her next piece of advice is: Figure out for yourself what you really want from your career and your life and then set goals accordingly. Because she knows firsthand that minorities entering the field often face barriers and obstacles that their white counterparts don't, she stresses the importance of developing a strong support network. "Your mentor doesn't always have to look like you," she adds, "but it sure does help."

She also emphasizes the crucial role that professional education has played in her success. "Education and training has been paramount in my development as an officer and a nurse. As a teacher, I love to help patients understand the importance of health care. I love seeing that light go on in people when they 'get it.'"

Ask her Navy colleagues what kind of a role model CDR Lenora Langlais is and their faces light up, too. "There is no greater example of dignity, honor, and compassion I can think of than her," Chaplain Byrd says. "To aspiring nurses she illustrates what it means to be a perfectionist. She gives to them the pride that can only come from a professional with a 17-year career of service. CDR Langlais challenges them and others to not settle for good, but to strive for great. By example, she teaches them to excel in their educational, professional, and personal goals."

–Denene Brox is a free-lance writer based in Kansas City, KS. Reprinted by permission from* Minority Nurse *magazine.

DOD Names Assistant Secretary of Defense for Health Affairs

The Department of Defense announced that Dr. S. Ward Casscells has assumed the duties as Assistant Secretary of Defense For Health Affairs.

In this position, Casscells will be responsible for overall leadership of the Military Health System, serve as the principal advisor to the Secretary of Defense for all DOD health policies and programs and oversee all DOD health resources.

Prior to his appointment, Casscells was a distinguished professor and vice president of biotechnology at the University of Texas Health Science Center in Houston and director of clinical research at the Texas Heart Institute.

Casscells received three Commandant's Medals from the U.S. Army Medical Research and Materiel Command. For his work on telemedicine and disaster medicine, Casscells received the General Maxwell Thurman Award. As an advisor to the Army Surgeon General for Hurricanes Rita and Katrina, Casscells received the Army Achievement Medal.

Casscells returned last December from a 3-month tour of duty in Iraq, where he helped create a protocol for health policy and medical administration in the region. He deployed to the Middle East and Asia to study avian influenza and assess the possibility of a pandemic.

He worked as the Army Medical Command's senior medical advisor for avian flu and pandemic flu. He also directed the Army's Disaster Relief and Emergency Medical Services Program and the Army's Texas Training and Technology against Trauma and Terrorism Program.

Rdml (lower half) Christine S. Hunter has been nominated for appointment to the rank of rear admiral. Hunter is currently serving as commander, Navy Medicine West, San Diego, CA.

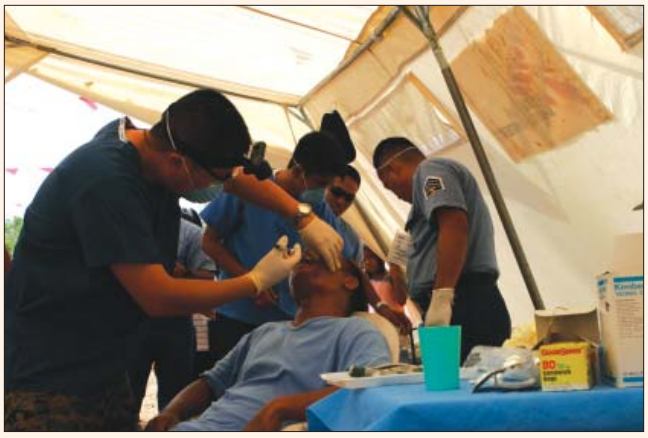
Rear Adm. (lower half) Adam M. Robinson Jr. has been nominated for appointment to the rank of rear admiral. Robinson is currently serving as commander, Navy Medicine Capital Area, Bethesda, MD.

HM Lucas W.A. Emch, 21, of Kent, OH, died 2 March when an improvised explosive device detonated in his vicinity while conducting combat operations in Al Anbar Province, Iraq. Emch was assigned to 1st Marine Logistics Group, 1st Marine Expeditionary Force, Camp Pendleton, CA.

HM1 Gilbert Minjares, Jr., 31, of El Paso, TX, died 7 February in a helicopter crash in Al Anbar Province, Iraq. Minjares was assigned to Marine Aircraft Group 14, 2nd Marine Aircraft Wing, Cherry Point, NC.

HM3 Manuel A. Ruiz, 21,of Federalsburg MD, died 7 February in a helicopter crash in Al Anbar Province, Iraq. Ruiz was assigned to the 2nd Medical Battalion, 2nd Marine Logistics Group, II Marine Expeditionary Force, Camp Lejeune, NC.

Kyung Ju, Republic of Korea. Children of the Seong Won Christian Orphanage race around the courtyard with Marines and sailors of the 31st Marine Expeditionary Unit during a youth-oriented community relations project. March 2007. Photo by CPL Kamran Sadaghiani, USMC



LT David Liu, DC, numbs a patient before performing a dental procedure as dentists from the Philippine Navy and Philippine National Police prepare to work on another patient. Photo by LCPL Daniel R. Todd, USMC

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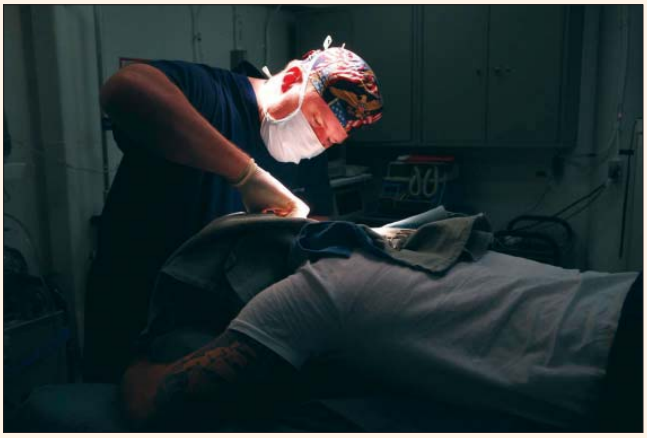
An Iraqi boy can't help but smile when a U.S. Marine lets him try on a kevlar helmet. Photo by CPL Luke Blom, USMC

Hickham AFB, Hawaii. HMC Jeffery Fisher stands in formation at the Joint POW/MIA Accounting Command's (JPAC) arrival ceremony for U.S. service members from the Korean War. An official delegation from the United States traveled to North Korea to accept the remains from the government. April 2007. Photo by MC2 Leeanna Taylor, USN



Pacific Ocean. LCDR John Ullrich performs cranial surgery on a crewmember aboard USS *Nimitz* (CVN-68). Photo by MC Eduardo Zaragoza, USN

Atlantic Ocean. Sailors assigned to repair locker one alpha conduct a general quarters medical emergency drill aboard USS *Harry S. Truman* (CVN-75). March 2007. Photo by MCSR Daron Street, USN

Magsaysay, Republic of the Philippines. HM3 Nina Kovacs ensures aseptic conditions are maintained on dental equipment during the Medical Civic Action Program (MEDCAP) portion of Exercise Balikatan 2007. Photo by MC2 Johansen Laurel, USN

FORCM Robert Elliott responds to a question during his recent visit to Navy Medicine Support Command, Jacksonville, FL. Photo by HM1 Terra Haidle, USN

Arabian Sea. HM1 Benjamin Morgan stitches a laceration on Aviation Boatswain's Mate Airman Apprentice Janssen Eilenberger in the medical ward aboard USS *John C. Stennis* (CVN-74). March 2007. Photo by MC3 Paul J. Perkins, USN

Sihanoukville, Cambodia. The guided-missile frigate USS *Gary* (FFG-51) and U.S. personnel provide local Cambodian nationals medical and dental treatment during a medical and dental community relations activity. *Gary* is the first U.S. Navy ship to visit The Kingdom of Cambodia in 30 years. February 2007. Photo by MC2 Barry R. Hirayama, USN

Navy Medicine Welcomes 10 New Lean Six Sigma Black Belts

Jacky Fisher
Doris Ryan

Knowing what Navy medicine's Strategic Business Plan is and how it will be accomplished is part of the program for 10 individuals who are completing several weeks of specialized training in Portsmouth, VA, to become Lean Six Sigma Black Belts. This group will lead project teams in each region as part of Navy medicine's continuous improvement efforts which focus on mission accomplishment and customer satisfaction.

These 10 people, selected from BUMED and the regions, will become the first Lean Six Sigma (LSS) Black Belts in Navy medicine. They have received special training in team building and problem solving and in implementing various business process improvement methods.

LSS techniques apply a structured, scientific method to improve business processes and empower personnel to make positive changes in their workplace. LSS combines two approaches to process evaluation and improvement. *Lean* is an analytical method used to identify wasted effort in an existing business process and focuses on streamlining for efficiency. *Six Sigma* is an evaluation method focusing on quality and aligns business processes with customer requirements and needs.

"Lean Six Sigma is a critical management tool that all of us are going to use to enable us to sustain key performance in the face of the changes and challenges before us," said CDR Steward Comer, MC, Director, Ancillary Services, Naval Medical Center, San Diego, and a Navy medicine Black Belt candidate. "That means every medical treatment facility has to operate the same way, which is so crucial because everyone is part of this overall organization of Navy medicine. We need to be tied together with one common management practice."

We have got to be able to link strategic initiatives to the ultimate performance at the deck plate level and that's what Lean Six Sigma is really going to offer us, added Comer.

Four broad focus areas that span the regions have been selected for the first year's initiatives, each supported by a regional commander. Comer's fellow Black Belts from Navy Medicine West are CDR Scott Lawry, MSC, a pharmacist at Navy Medicine West and CDR Carol Grush, Director of Public Health at Camp Pendleton. The focus for the Navy Medicine West team is the Maternal-Child product line.

In the Navy Medicine National Capital Area, the teams headed by CDR Patricia Bibeau, NC, Critical Care and LCDR Michael Ryon, NC, Division Officer Sterile Processing at the National Naval Medical Center, Bethesda, will focus on the Casualty Care Continuum.

At Navy Medicine East, CAPT John Cherry, NC, from Navy Medical Center Portsmouth and LCDR Max Cormier, NC, Department Head at Geiger Clinic at Naval Hospital Camp Lejeune will lead teams focusing on Individual Medical Readiness.

Bottom row, l to r:) Carolyn Keeseman; CDR Penny Walter; CDR Patrice Bibeau; Frances Kanach, Lean Six Sigma Master black Belt trainer; DeAndre Lyman, Lean Six Sigma Master Black Belt trainer. (Middle row, l to r:) CDR Scott Lawry; CDR Joe Myers; LCDR Max Cormier. (Top row, l to r:) CDR Carol Grush; LCDR Michael Ryon; CDR Stewart Comer; CAPT John Cherry.

At Navy Medicine Support Command, CDR Joe Myers, Assistant Director of Human Capital, and Ms. Carolyn Keeseman from the Navy Medicine Logistics Command will lead teams focusing on Procurement and Contracting processes.

The Black Belt in training for the Bureau of Medicine and Surgery is CDR Penny Walter, MSC. "A proven business philosophy and technique, Lean Six Sigma is capable of taking an organization to the next level," said Walter. "Lean Six Sigma will assist Navy medicine in its mission to deliver the finest medical care to our warfighters and their families."

Once the Black Belts complete their training they will work full-time on LSS projects and will be responsible for facilitating teams, seeing the teams through to the end of the project, and delivering results to leadership. Selected members of the workforce will be part

of process teams that will analyze how work is currently being done, identify unnecessary steps, and help formulate improvement recommendations.

"Black Belts cannot do this job alone," said CAPT Judy A. Logeman, NC, Director, Process Management and Integration at BUMED. "They need help from an experienced team whose membership is drawn from the Navy medicine workforce. There are also Green Belts, Yellow Belts, White Belts, and team members. These are individuals in the organization who receive some level of awareness education or skill training in LSS. They usually maintain their regular jobs, but work part-time on projects in their work place. They are extremely knowledgeable about the processes under study."

All organizations have room to improve and LSS is just the next evolutionary step on the continuous process improvement road we have been on for years. LSS provides a more focused and rigorous framework for looking at our processes, added HMCM Karen Sayers, a member of the BUMED Process Management and Integration team. No job is done so perfectly that another second of inefficiency or waste cannot be squeezed out. LSS will make an employee's job easier by reducing unnecessary work and eliminating duplication of effort. It makes work more valued and meaningful by improving work quality and empowering employees to have a voice in the process.

LSS uses many of the same tools and techniques as other quality initiatives supported by Navy medicine in the past. When Navy medicine started down the quality improvement road, the focus was on incremental changes in specific areas in a specific location. Over time the business process thinking has matured and now business management tools have become available to build on the past quality improvement foundation. LSS puts all of the elements together in a comprehensive system that is structured and disciplined and includes many points of accountability.

LSS is an investment in Navy medicine's future that brings the impact of wartime demands, national security requirements, recapitalization needs, and fiscal realities into the equation of how the business of Navy medicine meets customer needs.

"Navy medicine's commitment to serving our nation's heroes and their families compels full support for this transformation initiative," said VADM Donald Arthur, Navy Surgeon General. "Currently Navy medicine is deployed around the world providing preventive medicine, combat medical support, health maintenance, medical intelligence and operational planning. We must be flexible enough to perform a global war on terror mission, a homeland security mission, a humanitarian mission, and at the same time meet our mission to provide health care to our beneficiary populations. I am strongly committed to Lean Six Sigma as the foundation for transforming Navy medicine to meet our critical national security mission and institutionalizing a culture of continuous process improvement throughout our organization."

The focus of LSS is always customer satisfaction. Navy medicine serves two major customer groups, each with very different requirements and needs.

First is the warfighter. Navy medicine is an active player on the Navy-Marine Corps team—and as a member of the team, Navy medicine leadership must be able to implement decisions rapidly, shift resources quickly, coordinate assets to meet current mission requirements, and plan for future mission needs. The warfighter expects and deserves responsive, capable coordinated medical services anytime, anywhere.

Second is the beneficiary. All beneficiaries want convenient healthcare tailored to their individual health needs. Navy medicine manages and delivers a superb health care benefit and works to build a strong partnership with beneficiaries in an integrated health care deliver system that includes military hospitals and clinics, private sector care, and other federal health facilities like the Department of Veterans Affairs.

"Lean Six Sigma is a proven methodology that has the potential to optimize business and clinical processes throughout Navy medicine," said Logeman. "The Bureau of Medicine and Surgery has set the goal of institutionalizing LSS throughout Navy medicine and all its field activities and ensuring continued alignment with SECNAV, OPNAV, and the Military Health System LSS initiatives. Beginning in 2007, LSS will become an important element in BUMED's annual business planning process."

BUMED is establishing a LSS Center for Program Management Excellence at the Navy Medicine Support Command. This center will be responsible for project tracking, data collection and analysis, and training a cadre of professional project consultants, managers, and facilitators.

"Navy medicine has done well in implementing other models of performance improvement in the past and has found efficiencies and quality improvement through their employment," said Ms. Pat Craddock, Deputy Chief of Staff, Future Plans and Strategies, Navy Medicine Support Command. "What an enterprise approach to Lean Six Sigma has to offer is the ability to align these efficiencies and reduce variations across Navy medicine, bringing us closer to a franchise organization at our foundation while making us more agile and able to respond to customer requirements."

BUMED has set the goal of institutionalizing LSS throughout Navy medicine and all its field activities by 2009.

Jacky Fisher is Naval Medical Center Portsmouth Deputy PAO. Doris Ryan is a Public Affairs Specialist at the Bureau of Medicine and Surgery.

Marines and Sailors Provide Medical Care to Kenyan Community

LT Alin V. Ledford, surgeon for Combat Logistics Battalion 26, checks a child's breathing patterns. Photo by LCPL Patrick M. Johnson-Campbell, USMC

CAPT Steve Temerlin examines a child's leg during MEDCAP. Photos by MC2(AW) Jeremy L. Grisham, USN

Marines and sailors from the 26th Marine Expeditionary Unit and the USS *Bataan* (LHD-5) Strike group, along with Kenyan medical personnel, held a medical clinic for Kenyans 7-8 March.

The bilateral Medical Civil Assistance Project (MEDCAP), was held next door to the Bargoni Primary School, which was under renovation by elements of the 26th MEU and Kenyan Army, and was intended to provide care for residents of the approximately 15-square-mile area surrounding Bargoni.

LT Kyle E. Kee, MSC, medical planner for the 26th MEU, said the clinic would provide care the residents ordinarily would have difficulty getting access to. "We're here to provide Level-One medical care for the Kenyan citizens of Bargoni and the neighboring area," he said, "We want to provide care they themselves can sustain."

Over the course of the 2-day clinic, the medical personnel saw 261 local Kenyans. HM1(FMF, SW) Eduardo Linares, an independent duty corpsman with the 26th MEU's Combat Logistics Battalion-26, said the staff worked on a wide variety of conditions. "We saw things ranging from

HM2(SW) Damon Baldini takes the temperature of a small child.

LCDR Patty Miller examines a patient.

parasitic conditions, upper respiratory conditions, and a lot of skin conditions and infections," he said.

The clinic helped more than just the Kenyans' medical issues.

Kee said the project was intended to cultivate goodwill between the Kenyans and U.S. service members. "We are trying to foster civil-military relations, while at the same time maintaining, if not improving, healthcare, personal quality of life, and standards of living," he said.

In addition to helping the Kenyans, the medical staff considered the project good training. Linares said it gave the Americans a chance to diagnose and treat things they may not see very often. "It was a good experience," he said, "We got to see some stuff we don't normally see in the U.S., and at the same time we got to train the junior corpsmen."For many of the younger service members, this was their first time in an area such as Kenya. HM3(FMF) Jonathan R. Underberg said he never dreamed he would be doing this when he joined the Navy. "When I saw the recruiter's poster I knew I would be on the ocean," he said, "but I never thought I would be in Africa doing a clinic." Underberg said he was proud he got a chance to help.

The 26th MEU is comprised of the Command Element; the Ground Combat Element, Battalion Landing Team 2/2; the Logistics Combat Element, Combat Logistics Battalion-26; and the Aviation Combat Element, Marine Medium Helicopter Squadron-264 (Reinforced). The 26th MEU, along with the ships of the Bataan Strike Group, USS *Bataan* (LHD-5, USS *Oak Hill* (LSD-51), USS *Shreveport* (LPD-12), USS *Nitze* (DDG-94), USS *Vella Gulf* (CG-72), USS *Underwood* (FFG-36) and USS *Scranton* (SSN-756), deployed in early January on a routine, scheduled deployment.

–Story by LCPL Aaron J. Rock, 26th MEU, Bargoni, Kenya.

A Surgeon Remembers Khe Sanh

From January through April 1968, an estimated 20,000 to 40,000 North Vietnamese troops besieged the Khe Sanh combat base 15 miles south of the Demilitarized Zone (DMZ). The base, located in the northwest corner of South Vietnam, was a mere 6 miles from Laos. Defending it were 5,000 men of the 3rd Marine Division.

Prior to the beginning of the siege, two battalions of the 26th Regiment's three battalions were stationed in or around Khe Sanh. On 22 January, the day following the first major attack, four battalions were in place: the 1st, 2nd, and 3rd Battalion, 26th Marines, and 1st Battalion, 9th Marines. Three battalion aid stations serviced the 26th Regiment, each staffed by one general medical officer. Charlie Med, the base's largest medical facility, had three or four doctors—a surgeon, an anesthesiologist, and two general medical officers. A regimental surgeon was also assigned to the 26th Marines, but his role was never precisely defined. When business was brisk after a major shelling, Charlie Med's staff gladly accepted the surgeon's assistance.

When he arrived at Khe Sanh, 3rd Medical Battalion surgeon LT James Finnegan had already paid his dues as a surgeon at Delta Med in Dong Ha. He had been "operating on casualties and ducking the incoming" for 4 months. When Delta Med's commanding officer, CDR Bob Brown, asked him to head the surgical team at Khe Sanh's Charlie Med, Finnegan agreed. As he jumped off the Huey gunship at the combat base, two men jumped on so quickly that he hardly saw their faces. One was the surgeon he was relieving, and the other was Charlie Med's anesthesiologist. "So I was there and they were gone."

There I was the new CO of Charlie Med. [LT] Eddie [Feldman] had been with one of the hill companies—1/26 [1st Battalion, 26th Marines]. [LT] Don Magilligan was out there with one of the other Marine companies. They pulled them in to work with me. So I had Ed, Don, and [LT] Joe Wolfe plus 26 corpsmen.

When I got up there, Charlie Med was a little compound right on the side of the runway because—for evacuation purposes—we had to be right on an airstrip. Everything was all canvas tents with sandbags. The tents had holes in them and were flopping all over the place. It was madness!

Not too long after I arrived, incoming artillery ratcheted up to 2,000 rounds a day. Eventually the incoming got so bad that all fixed wing aircraft were banned from Khe Sanh. Then it got to the point where even getting a helicopter in and out was very dangerous. They would land and then take off in a flash! They didn't sit on that strip but for a few seconds because the minute they landed, it was unbelievable. And, of course, Charlie Med always got the secondary effect of that added incoming because the helicopters parked right in front of us.

Within a very short time, we had nothing above ground that hadn't been blown away. The corpsmen and I had little bunkers that were dug down maybe 3 feet in the ground with sandbags and wood on top of them. At the triage area, we just had sandbags and wood. The incoming seemed unrelenting. It was probably less at night. I don't know whether anyone has ever documented incoming rounds. I've always had this impression that the North Vietnamese did not like to fight at night. Maybe nobody does. But no matter where I was—even at Delta Med—it was less at night. If we went to our underground bunker at night, we could sometimes be in there with not too much happening.

But daytime was different. Even taking the catwalk—the wooden planks that led up from the bunkers—was a risk. We had spotted a sniper across the way, and you could never just get up and take the catwalk. You'd jump on and off of it because no one wanted to get picked off by that sniper. But as soon as we had casualties, we'd all charge from the bunkers up to the triage, which was in front right near the airstrip.

One of the hardest tasks was first offloading the casualties. The minute the chopper would drop in, the incoming would pick up. We called the choppers "mortar magnets." You'd run out, get the casualties off the chopper as fast as you could, and they would just lift off and go as fast as they could. Then you had to bring the litter about 20 yards from the landing pad into Triage.

It was the same procedure if you were evacuating casualties. Once we got everybody stabilized and the situation was quiet, we'd call for choppers to get them over to Dong Ha or wherever else they were going. And, of course, as soon as the

chopper came in, the incoming would start. We had to set up a wall of sandbags from the door of the triage bunker to the helicopter pad so we could run low behind the sandbags and try to get to the chopper without getting hit.

Every morning I was supposed to go down to a regimental briefing. A lot of mornings we had to run from truck to truck or pole to pole because of the incoming, even as you tried to walk down the path. The briefing was an out-of-body experience for me as I sat there and listened to these guys. COL [David] Lownds was the CO of the 26th Marines at Khe Sanh. The rest of the officers were also there. Every morning they went through the intelligence reports. One officer would say, "Outside Z2 R1 Perimeter we heard these clanking noises which we think were tank treads."

Tank treads! I'm thinking, "Jesus, they've got tanks!"

Other reports would focus on the incoming, or on a patrol that went here or there, or on enemy sightings. Then, every once in a while, Lownds would refer to the "impending invasion of Khe Sanh"—what forces the NVA had and how they were going to come in.

I pointed out that we needed some kind of protection at Charlie Med because we were getting shelled as we were caring for the casualties. I didn't see that I was getting anywhere with that argument. Finally, I had a discussion with the executive officer. "Some of these kids are getting re-wounded. It's not a good thing. It's bad enough they get wounded the first time."

And to this day, I still don't know who said what to whom, but sometime after that discussion a group of Seabees came over with a backhoe. They dug a good-sized hole in the ground, maybe 12 by 20 by 10 feet deep, which they buttressed with 12 by 12s. They then put metal Marston matting [pierced steel planks] on the top with layers of sandbags on top of that. They also built a little ramp going down into it.

Now we finally had a place where we could take the casualties! It was a pain in the ass to have to take them down the steps into the bunker, but at least we were in there with some notion of being able to stand up and take care of them without worrying about getting hit.

Photo courtesy of Dr. Ed Feldman

3rd Medical Battalion physicians take a break above ground during a lull in the shelling. (l-r: LT Joe Wolfe, LT Jim Finnegan, LT Ed Feldman, LT Don Magilligan)

Lownds now felt that the NVA's attempt to overrun Khe Sanh was imminent. I remember seeing a picture of the base very clearly. The picture had curved arrows showing five routes onto the base: the primary route where the NVA were most likely to come in over here or over here, and the third route up the draw through Charlie Med. Well, that last arrow got my attention. The perimeter was a hundred yards and you could see the NVA running around out there right across the strip. You could see them through binoculars. And right behind us was a half track [vehicle with wheels in the front and caterpillar treads on the rear] with a .50 caliber machine gun on it and a couple of Marines. That was it.

I waited until the briefing was over because I never felt I had enough military moxie to even ask a question. These were all Marine combat professionals. So I got the executive officer afterwards and said, "Listen, I don't exactly know what I'm supposed to do here. I've got four docs who wear .45s and are in danger of shooting themselves in the foot at any given moment. I have 26 corpsmen who don't carry weapons because they're working on casualties, and a little half track out there. You're drawing an arrow saying that there's at least a reasonable possibility when they overrun this place—which you're absolutely certain they're gonna do at any moment now—that they might come right up the draw through Charlie Med. I'm not John Wayne. I cannot be taking care of a casualty and shooting the enemy while I'm doing it. This is not the movies. Seriously, can you put some Marines out there?"

He answered, "Don't worry, Doc. If they come up through there, the reaction force will come right away."

I asked, "Well, how long is it gonna take for them to get there if we're triaging casualties?"

He replied, "Doc, it probably will take them a little while for them to be activated and be ordered over there."

I said, "When I go back, what do you want me to tell my guys? What am I supposed to do?"

He countered, "I understand that when the casualties come in, you strip them and take their weapons." He then added, "Don't you take all the weapons from the casualties?"

I said, "Of course."

"My suggestion," he added, "is to go back and make sure that your docs and corpsmen all have sidearms, M16s, and grenades and that you also dig fighting holes."

That's what he told me. As I walked back to Charlie Med, I thought, "Now, there's just no way that I can say to all these guys, 'Okay. We're all gonna strap on our .45s and carry an M16, put some grenades in your lapels like John Wayne, dig your foxhole, and we'll keep taking care of the casualties. If they come up the draw, we'll become a Marine platoon.'"

In all triage setups, the wooden "ammo box" sits behind the tent wall. We'd set the casualties' M16s against the wall. If they had bandoliers or grenades, we'd throw them in the box. When I think about it now, if you handed me a grenade, I'd run screaming out in the hall.

The whole situation seemed like madness, absolute madness! So I decided that I was not going to say that to the guys. We all knew the Marines were very concerned that the enemy was going to overrun the base. We felt that at any given time the NVA could try to take the base. Everyone was aware of that fact as the siege went on. That's what it was all about.

With the incoming so bad, they started air-dropping supplies. It was one of those tragic comedy situations because we would watch the planes come over—mostly C-130s—with the rear hydraulic doors down so they could drop the load off the back. We would watch the stuff coming down. Let's say that a significant percentage of it didn't land in Khe Sanh. As a result, parachutes were spread all over hell's half-acre. Sometimes we had to send out a combat patrol to rescue the supplies.

Right outside of Charlie Med was a huge collection of used parachutes, open and sprawled all over the place. Everybody knew the plan was for "Charlie" [NVA] to come over the wire and get us. The Marines were actually begging for it. In all fairness, at least the senior veteran Marines wanted them to come. This is what Marines are born for. In that context, rather than say to the men, "Get your M16 and dig a fighting hole," I said, "Guys, I've got a plan. We have lots of casualties to take care of and we can't be worried too much. We've got the Marines down there. If we see the enemy break through and come up that draw, what I suggest is that everybody get under the parachutes. The enemy will never know we're there. They will roll right on by, and then we can go back and get our guns." At least I got a laugh from the guys. That was my famous parachute speech to the troops.

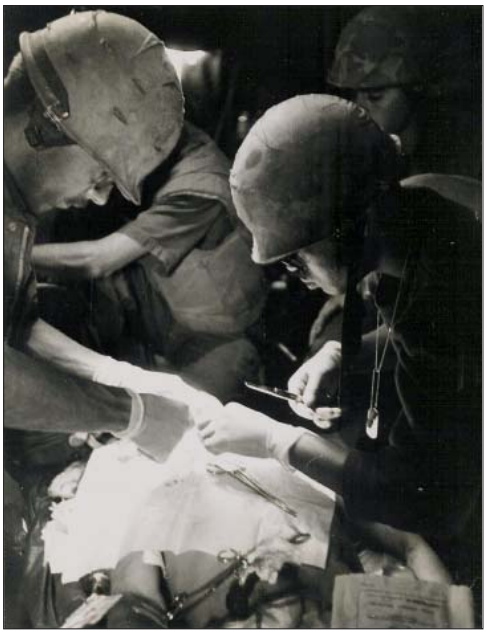
I recall many patients we worked on but none more than Jonathan Spicer. In fact, the Jonathan Spicer story has been written up in many places. It's one of the many stories that came out of Khe Sanh.

Jonathan was the son of a preacher from Miami. I think he was drafted into the Marine Corps. According to the story, he immediately informed his superiors that he was a conscientious objector. He would do anything they wanted but he wasn't going to fire a gun. Somehow he was passed through basic and ended up in Vietnam. Once he got there, he was assigned to a Marine hill unit. He kept saying to his superiors, "I'll do whatever you want me to do but I will not fire a gun."

His CO was so disgusted with Spicer that he was going to discipline him in some way. But someone else said, "Let me take him and maybe he can do something else." And so they brought him to me at Charlie Med.

He wasn't a corpsman. He was a grunt Marine. The kid was not a coward. He just didn't want to be a shooter. So he became our main litter-bearer. He would run back and forth to the choppers under fire. This kid was fearless. We loved him. I still remember the day we were standing down in the bunker—Don Magilligan, Eddie [Feldman], and I. Suddenly somebody yelled, "Spicer's down!" He was moving litters and took shrapnel right through the center of his chest.

They brought him quickly into Triage, right onto the first litter. He was gone. No pulse. No blood pressure. Don Magilligan was standing beside me and said, "I think it's pericardial tamponade." This means the blood in the heart sac is compressing the heart. If a fragment penetrates the heart, first it has to go through the heart sac—the pericardium—then into the heart. If the heart sac hole is small enough, the blood will spurt out of the heart and build up in the sac and compress the heart.



BUMED Archives

LT James Thomas (r) performs emergency surgery in a bunker during the siege.

I said, "Don, I think you're right." So we opened his chest, massaged his heart, put a single stitch in the hole in his heart, and his vital signs came back. Everything seemed dandy. He had been intubated with an endotracheal tube and we got him stabilized.

We then called Delta Med and told them that Spicer had an open chest wound, a sutured hole in his heart, and that we had to get him out of Khe Sanh and back to Delta Med big time. We couldn't keep anybody at Khe Sanh. Once we stabilized them, we had to get them the hell out because we didn't have the facility to do anything else.

Spicer was medevaced and for a long time nobody could find out what happened to him. I heard all kinds of stories, including one that he had died. We finally got information that he was medevaced first to Danang and then to Japan. He died in Japan "of infection." It's hard to know exactly what that means. But because of his heroism, he got the Navy Cross.

At that time a tremendous amount of newsprint covered the Jonathan Spicer story. We were very excited because we thought we had saved our boy. Years later I saw his name on the Wall.

Dr. Finnegan practices thoracic surgery at the Cooper University Hospital in Camden, NJ.

CDR Nancy J. "Bing" Crosby, NC, USN (Ret.), veteran of the Korean War, died on 28 March. She was 81. CDR Crosby was born in Baltimore, MD, on 23 January 1926. She then received her B.S. degree from the University of Pennsylvania, and went on to Boston University for her Masters degree. In an interview with *Navy Medicine*, CDR Crosby pointed out that both her brothers also joined the Navy. "One went to the Naval Academy, and my other brother served in submarines. I was the only one that had to go to war."

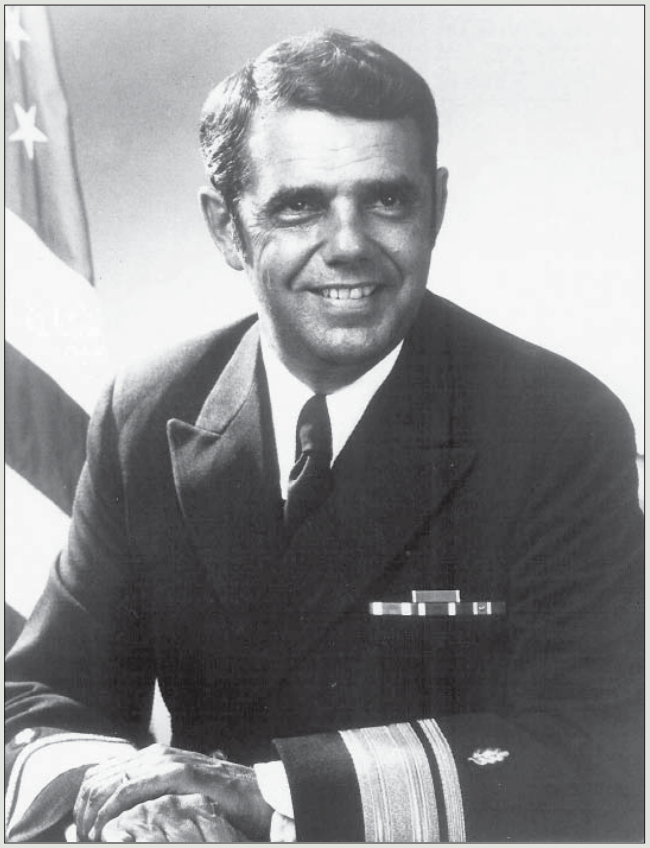
Her first assignment was to the National Naval Medical Center, Bethesda, MD, followed by duty 2 years later at Naval Hospital Beaufort, SC. When the Korean War broke out in June 1950, then ENS Crosby volunteered for duty aboard USS *Haven* (AH-12), where she served for 2 years. As a surgical nurse, she cared for many of the wounded who had been evacuated to the hospital ship.

LTJG Crosby and friend, Korea 1952. Nancy Crosby Collection, BUMED Archives

LTJG Crosby was aboard *Haven* at Inchon Harbor when two wooden decked rafts were moored on either side as landing platforms for inbound medevac helicopters. These floats served the hospital ship until a permanent helo deck could be installed. Crosby's great skill as a photographer captured the first helicopter landing on those decks. (See Images from the "Forgotten War," *Navy Medicine*, March-April 2002, pp. 17-23).

CDR Crosby retired in 1969, and spent many hours as an award-winning artisan. Bird-carving was her specialty. She returned to South Korea in 2002 as a guest of the South Korean government. Her impressions of that trip appeared in an article entitled "Korea 50 Years Later," published in the September-October issue of *Navy Medicine*.

RADM Melvin Museles, MC, USN (Ret.) died on 12 March at his home in Jupiter, FL. He was 77. Dr. Museles was born in Boston, MA, on 24 October 1929. He graduated from Boston University in 1950 with a B.A., and received his M.D. from Tufts University Medical School in 1954.



Dr. Museles began his Navy career as an intern at Naval Hospital Chelsea, MA, in 1954 as a lieutenant (j.g.). He received his residency training in pediatrics at the same institution and at the Children's Hospital Medical Center, Boston, from 1955-1957. Following a tour at Naval Hospital Guantanamo Bay, Cuba, he entered civilian practice but returned to active duty after only 9 months. He then served as Assistant Chief of Pediatrics at Naval Hospital Chelsea, from 1959 to 1962. Following several tours as chairman of the Departments of Pediatrics at Naval Hospital Portsmouth, VA (1962-1967), and NNMC Bethesda (1967-1971), he was appointed first as Assistant Head, Training Branch, BUMED and then as Head, Training Branch, in 1972.

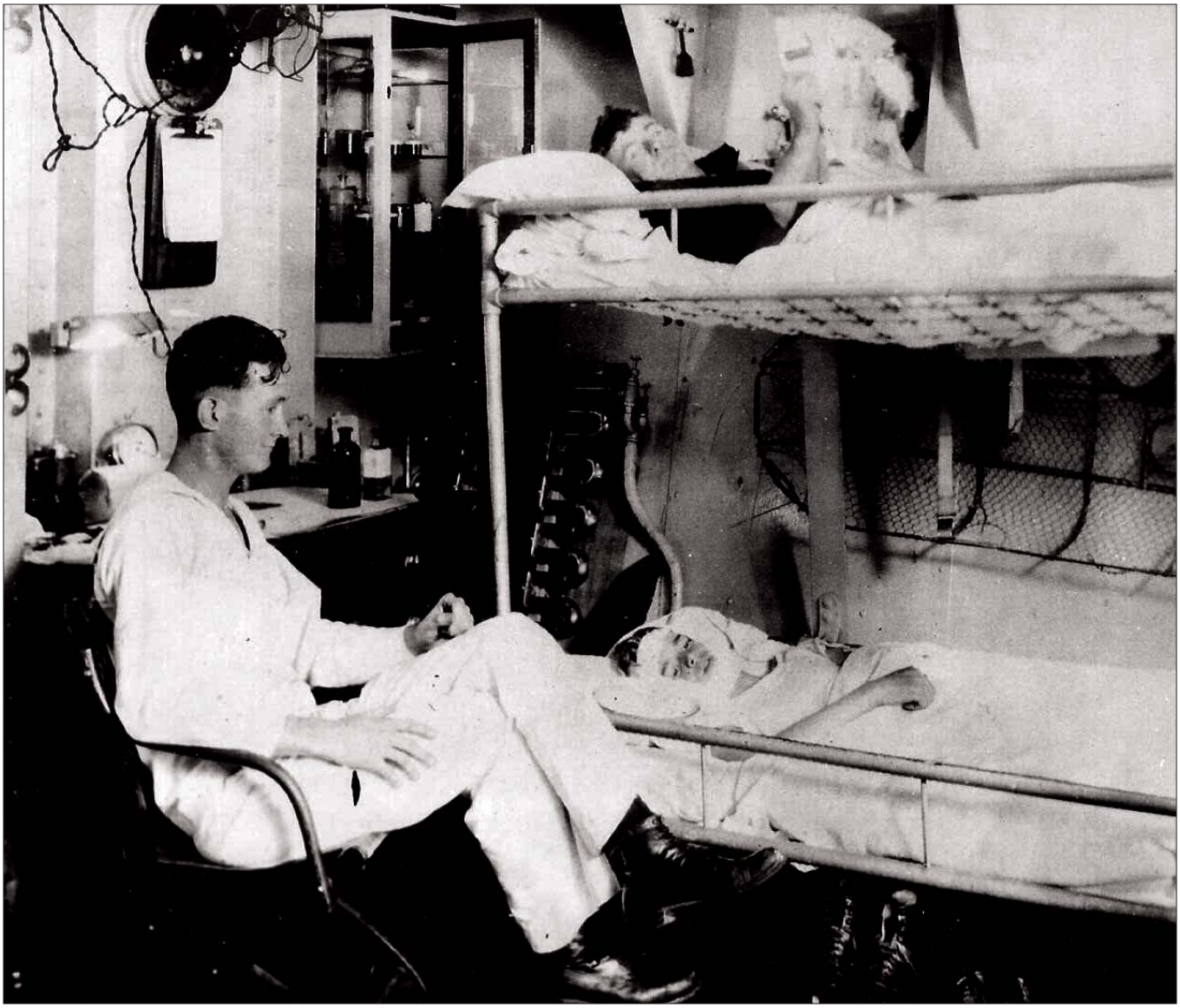
In 1973 Dr. Museles was selected as the first Executive Secretary to the Board of Regents of the Uniformed Services University of the Health Sciences by the Secretary of Defense. In 1974 he was also appointed the first Associate Dean of the same institution. In these positions, he played a leading role in the initial development of the university and its relationships with the military teaching hospitals. In 1976, he assumed command of Naval Regional Medical Center Jacksonville, FL.

Dr. Museles was promoted to rear admiral in 1978 and assumed duty as Inspector General, Medical, BUMED. The following year he became Assistant Chief for Professional Development.

RADM Museles was board certified in pediatrics and held academic appointments as Clinical Professor of Pediatrics at Georgetown University Medical School and as Associate Clinical Professor of Pediatrics at Howard University Medical School. He was a fellow of the American College of Physicians and the American Academy of Pediatrics. He also held the title of Pediatrician to the White House during the Johnson administration.

RADM Museles's military awards included the Legion of Merit, the Meritorious Service Medal, the Navy Commendation Medal, and the National Defense Medal with Bronze Star.

Navy Medicine ca. 1914



BUMED Archives

Sick Bay USS *Prometheus* (AR-3)

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